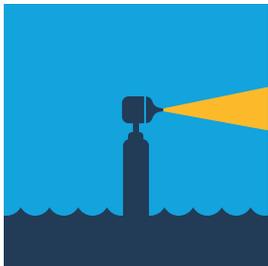


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The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

INTRODUCTION

Since the advent of managed care, the number of advanced practice providers (APPs) has grown rapidly. This group of healthcare professionals—also described as “physician extenders,” “mid-level practitioners,” and “allied health providers”—can be found in a wide variety of specialty areas and in clinical settings that include hospitals, outpatient clinics, and rural community centers. This group comprises many types of clinicians, such as nurse midwives, nurse practitioners, physician assistants, and nurse anesthetists. Currently, the two most prevalent APP categories are nurse practitioners and physician assistants.

The American Academy of Physician Assistants (AAPA) estimates that more than 123,000 physician assistants practice in every medical setting in all 50 states and the District of Columbia. The American Academy of Nurse Practitioners (AANP) estimates that more than 234,000 nurse practitioners are licensed in the United States.

Today, APPs are important members of the healthcare team. APPs can obtain and record health histories, perform physical assessments, order diagnostic tests, and prescribe medications for patients—activities that have resulted in time savings and cost savings for physicians.

As the number of practicing APPs increases, so does the potential for liability exposure. This guide is an essential reference for practitioners who employ or supervise advanced practice providers.

NUMBER OF ADVANCED PRACTICE PROVIDERS IN THE UNITED STATES

123,000

Physician Assistants

—AAPA, 2017

234,000

Nurse Practitioners

—AANP, 2017

DEFINING ADVANCED PRACTICE PROVIDERS

The APP group includes many types of providers.

Physician Assistant

A physician assistant (PA) is a licensed professional trained to provide patient evaluation, education, and healthcare services as part of a physician-PA team. PAs must complete a training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). Graduates of an ARC-PA-accredited program may be certified by the National Commission on Certification of Physician Assistants and use the title PA-C to indicate current certification. PAs must be licensed by the state in which they practice, and many states also require that PAs complete training specific to the medical specialty in their area of practice. PAs can usually prescribe medications according to state formulary guidelines. Additionally, many states require PAs to complete an advanced pharmacology course and/or specific training for prescribing controlled substances. When selecting an appropriate PA candidate, a physician should match the PA's training with the medical specialty in which the PA will practice. The supervising physician must also adhere to the state's maximum PA-to-physician ratio and supervisory requirements.

Physician Assistant—
can usually prescribe
medications according to
state formulary guidelines.

Advanced Practice Registered Nurse

An advanced practice registered nurse (APRN) is a registered nurse who has completed advanced nursing education and certification to practice as one of the following providers:

▶ Nurse Practitioner

A nurse practitioner (NP) is a registered nurse with a master of science or doctor of nursing practice degree who has obtained training and certification in the area of specialty. NPs generally work in primary care, specializing in family, geriatric, pediatric, or women's health. The scope of practice is defined by a state's board of nursing. Unlike the PA, who must practice under a supervising physician, states may allow independent NP practice, require direct oversight, or require collaboration with a physician. In states that allow full practice authority (23 states and the District of Columbia), NPs may practice in an unrestricted manner, but their scope of practice is circumscribed by the state's advanced nurse practice act. An additional 15 states allow NPs to practice under a collaborative agreement with a physician. In these instances, the physician must comply with the state law requirements and the requirements of the collaborative agreement. The remaining 12 states require supervision, delegation, or team management of the NP.¹ While an NP may be allowed by state law to prescribe medications, most states require advanced pharmacology courses to meet established regulations. Check the state board of nursing for required NP licensing and elements of practice.

Nurse Practitioner—
most states require advanced
pharmacology courses to
meet established regulations.

▶ Certified Nurse Midwife

A certified nurse midwife (CNM) is a registered nurse who has obtained specialized training in midwifery through a master's or doctoral degree program, is certified by the American Midwifery Certification Board, and is licensed by the state in which he or she practices. A CNM manages women's health throughout the patient's lifespan, including family planning, annual exams, pregnancy, birth, and postpartum care for uncomplicated obstetrical patients. The scope of practice for a CNM is defined by a state's board of nursing and may include independent authority or require supervision or collaboration with a physician.

Certified Nurse Midwife—
the scope of practice for a
CNM is defined by a state's
board of nursing.

▶ **Certified Registered Nurse Anesthetist**

A certified registered nurse anesthetist (CRNA) is a registered nurse with a master of science or doctoral degree from an accredited nurse anesthesia program. The CRNA must hold certification from the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA), the Continued Professional Certification (CPC) Program, and nursing licensure from the state of practice. While some states continue to require supervision of CRNAs by a qualified licensed physician, others have opted out of the federal supervision requirement. Check federal guidelines and your state board of nursing for supervision requirements in your state of practice. State licensing regulations often define the ratio of CRNAs to supervising physician and the underwriting guidelines of most professional liability insurers.

Certified Registered Nurse Anesthetist—check federal guidelines and your state board of nursing for supervision requirements.

▶ **Clinical Nurse Specialist**

A clinical nurse specialist (CNS) is a registered nurse with a master of science or doctor of nursing practice degree and national certification in a specialized area of nursing involving care for certain patient populations (e.g., pediatrics), specific settings (e.g., critical care), types of diseases (e.g., diabetes), particular clinical specialties (e.g., oncology), types of care (e.g., rehabilitation), or types of problems (e.g., pain). A CNS is often found in a hospital setting providing direct patient care, performing patient or staff education, and overseeing clinical protocols but may also be a part of a primary or specialty care physician practice. The scope of practice for a CNS is defined by a state's board of nursing and may include independent authority or require supervision or collaboration with a physician. They have independent practice authority in 28 states and may prescribe independently in 19 states. Thirteen states require collaborative agreements with a physician, and 19 states require an agreement with a physician in order to prescribe medications and durable medical equipment.²

Clinical Nurse Specialist—the scope of practice for a CNS is defined by a state's board of nursing.

Anesthesiologist Assistant

An anesthesiologist assistant (AA) is a graduate of an accredited program who works under the direction of a licensed anesthesiologist to assist in the implementation of anesthesia care plans. An AA may not practice outside of the field of anesthesia or apart from the medical direction and supervision of an anesthesiologist. AAs may obtain national certification and use the title certified anesthesiologist assistant (CAA).

Anesthesiologist Assistant—an AA may not practice outside of the field of anesthesia.

References

1. West JC. Case law update: advanced practice clinicians. *J Healthcare Risk Manage.* 2016;36(2):51.
2. Scope of Practice. National Association of Clinical Nurse Specialists website. <http://nacns.org/advocacy-policy/policies-affecting-cnss/scope-of-practice/>.

ADDING AN APP TO YOUR PRACTICE

Like any other business decision, hiring an APP requires planning. Consider the volume of your practice, patient demographics, patient expectations and acceptance, and the managed care/payer reimbursement system (which may be less for APP services).

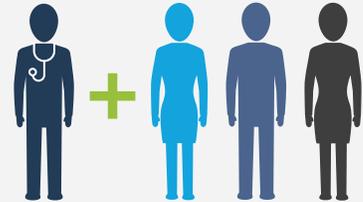
APPs are often hired to facilitate communication between the practice and the patient. APPs generally provide greater detail on follow-up care and specific care instructions and can answer patients' questions under less rigid time constraints than a physician.

Increasingly, group practices offer patients the option of seeing an APP immediately versus waiting for an appointment with a physician. Numerous studies indicate that the majority of primary care office visits can be (and increasingly are) adequately handled by APPs. Although the majority of APPs are employed in group practices, increasingly, more solo and small practices are hiring APPs.

The benefits of including an APP on a treatment team include:

- ▶ Faster patient access to healthcare.
- ▶ Increased physician time to focus on more difficult medical cases.
- ▶ Improved patient education.
- ▶ More thorough medical record documentation.
- ▶ Broader cross-coverage and after-hours on-call coverage.
- ▶ Enhanced patient satisfaction.
- ▶ Lower operating overhead and other economic benefits.

FAQs



How many APPs is a physician allowed to supervise?

The ratio of APPs to supervising physician varies. While the American Medical Association does not state a specific ratio, it recommends that the appropriate ratio of physician to APPs should be determined by physicians at the practice level, consistent with good medical practice and state law where relevant. In some states, the ratio is specified and may be based on whether the APPs are furnishing or prescribing medications. It is also important to maintain a ratio consistent with any terms specified in your professional liability policy language.

UNDERSTANDING THEORIES OF LIABILITY

Physicians and APPs should be aware of the theories of liability. It is essential that APPs provide care and treatment only within their scope of practice and that they consult with supervising physicians on complex cases.

Direct Liability for Negligence

A physician or an APP can be held directly liable for his or her own acts or omissions. This situation can occur when an individual renders care that deviates from the acceptable standard of care and causes harm or injury to a patient. This concept is based on the theory of negligence, the most common theory of liability in a medical malpractice action.

The four elements of a negligence cause of action include:

- 1 Duty** (the physician's or APP's legal duty of care to the patient).
- 2 Breach in the standard of care** (failing to act as a reasonably competent physician or APP would act in the same or similar circumstances).
- 3 Causation** (the physician's or APP's actions or failure to act caused the patient's injuries).
- 4 Harm** (the patient suffered harm or damages).

Vicarious Liability for Negligence

Vicarious liability is a legal theory that holds one person liable for the negligent acts, omissions, or torts (wrongful acts or infringement of a right) of another person because of some relationship between them. It is often used to hold a physician liable for the acts of an APP.

Respondeat superior, the common law doctrine meaning “let the master answer,” is one type of vicarious liability. Under this doctrine, a physician can be held liable for his or her employees' negligent acts or omissions that happen during the course of employment. This theory is often used to hold physicians liable for the acts or omissions of an APP. This situation can occur even when the physician did not personally treat the patient. Liability could arise because the physician employs the APP or because it is the physician's responsibility to supervise or oversee the APP.

An example is when patient harm results from an APP's missing a diagnosis. Although the APP may be the direct caregiver and the person responsible for the error, his or her employer—the supervising or overseeing physician—can be held vicariously liable. The intent is to ensure that the injured party has a right to full recovery from the entity or provider directing the employee's actions.

Agency theory may also be used to hold the physician vicariously liable for the negligent acts or omissions of the APP, even when an APP is classified as an independent contractor. If it appears to the public that an agency relationship exists between the two individuals, it might be reasonable to assume that the APP is acting as an agent of the physician. In most states, APPs are required to have some level of physician oversight—which means that it would be difficult for a physician to avoid vicarious liability simply by classifying an APP as an independent contractor.

Direct Liability for Negligent Supervision

An allegation of negligent supervision can arise when a physician allows an APP to function beyond the scope of license or when an APP does not receive adequate supervision or oversight for services rendered to patients. However, the definition of what constitutes appropriate collaboration or supervision of an APP can vary greatly from state to state. PAs are regulated by the state medical board, and NPs are regulated by the state nursing board. It is imperative for physicians and APPs to be thoroughly familiar with and remain current on the prevailing state laws and regulations.

For example, in California, with a proper written delegation of services agreement, the physician can demonstrate the appropriate supervision of a PA by: (1) examining the patient the same day he or she is treated by the PA, (2) reviewing and countersigning every medical record within 30 days, or (3) adopting written protocols to specifically guide the PA's actions. Then, within 30 days, the physician must review, sign, and date at least 5 percent of the records for patients treated by the PA. As a risk management and patient safety measure, the records selected for review should be cases that represent the most significant risk for patients.

Considerations for physicians and APPs when determining the roles and responsibilities of APPs in the practice include: the number of APPs a physician can legally supervise or oversee, criteria for medical record review and documentation, requirements for obtaining and maintaining prescriptive privileges, criteria for consulting with a supervising or overseeing physician, requirements for written delegation of services or collaboration agreements, and requirements for written treatment protocols between a physician and an APP.

Direct Liability for Negligent Hiring and Credentialing

Physicians are responsible for ensuring that their staff members are qualified and properly licensed. It is imperative to prescreen an APP's background and references thoroughly and to verify the APP's licensure status directly with the licensing authority. Further recommendations to consider when hiring and credentialing an APP can be found in the "Employment and Contracting Concerns" chapter.

CASE EXAMPLE

Vicarious Liability for Negligence and Direct Liability for Negligent Supervision:



A 53-year-old female underwent a laparoscopic cholecystectomy that was performed by the general surgeon without incident. The surgeon saw the patient three days post-op, noting that she was doing well and had no complaints other than the expected incisional pain.

The patient was next seen at five days post-op by the surgeon's PA. The PA noted an obvious infection at the umbilical surgical wound. He obtained a culture that later proved to be *Klebsiella* and started the patient on Levaquin.

The patient returned four days later and was reevaluated by the surgeon, who noted that the wound still looked infected and that drainage was present. The surgeon felt that the patient had cellulitis. He continued the antibiotic and advised her to return if needed.

A week later, the patient returned and was seen by the PA. She complained of recent onset of nausea, vomiting, and diarrhea and had a temperature of 103 degrees. Although the PA noted that the wound still appeared infected, he diagnosed the patient as having a superficial wound infection and gastroenteritis because her abdomen was not tender and he felt no masses. The PA told the patient to continue the Levaquin and prescribed Phenergan for the nausea and vomiting.

Three days later, the patient was admitted through the ER with sudden, severe abdominal pain. She underwent exploratory surgery and was diagnosed with an intrahepatic abscess. The patient developed disseminated intravascular coagulation, continued to deteriorate, and expired several days later.

A suit was filed against the surgeon, the PA, and the surgeon's medical practice. The primary issue of negligence was the failure to diagnose and treat the intrahepatic abscess. Defense experts could not support the PA's failure to properly assess the patient when she presented with obvious clinical signs of infection. The PA was criticized for failing to consult with the surgeon. The surgeon, who signed off on the PA's medical management of the patient, was held vicariously liable for the acts of the PA and directly negligent for inadequately supervising the PA.

PHYSICIAN ASSISTANT AND NURSE PRACTITIONER CLOSED CLAIMS STUDY

The Doctors Company analyzed 649 claims* against PAs and NPs that closed between 2012 and 2017.† Of these claims, approximately 60 percent were against PAs and 40 percent were against NPs.

The study examined whether the PA or NP was primarily responsible for the outcome of care that prompted the claim. Regardless of the outcome, we included all cases that closed within the time frame of the analysis. This approach provides a better understanding of what motivates patients to pursue claims and a broader overview of the system failures and processes that resulted in patient harm.

Claims against NPs and PAs



This study, reinforced by expert insights, focuses on the following areas:

- ▶ Most common patient allegations.
- ▶ Injury severity.
- ▶ Factors contributing to patient injury.

Our approach to studying APP malpractice claims began by reviewing plaintiffs'/patients' allegations, giving us insights into the perspectives and motivations for filing claims and lawsuits.

We reviewed patients' injuries to understand the full scope of harm. Physician experts for both the plaintiffs/patients and the defendants/providers reviewed claims and conducted medical record reviews. Clinical analysts drew from these sources to gain an accurate and unbiased understanding of events that lead to actual patient injuries.

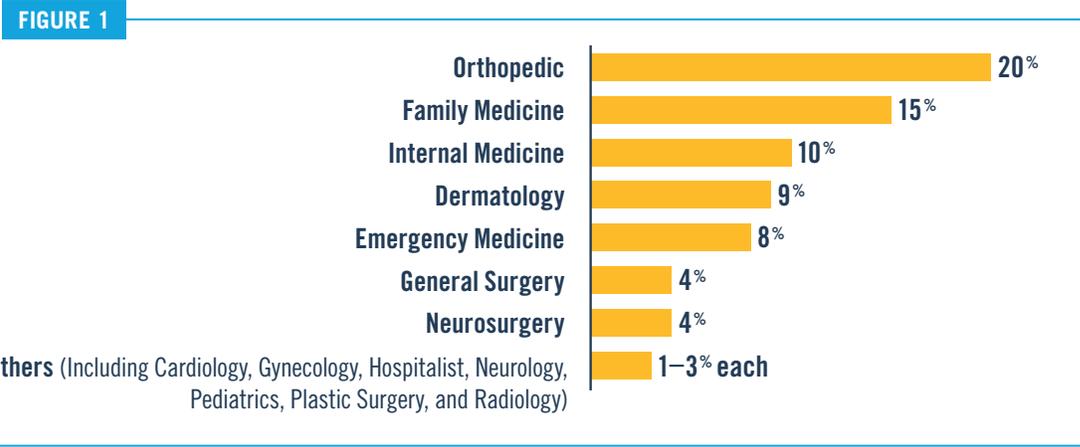
To prevent injuries, it is essential to understand the factors that contribute to patient harm. The study identified these factors, and physician reviewers evaluated each claim to determine whether the standard of care was met. Contributing factor categories included clinical judgment, technical skill, patient behaviors, communication, clinical systems, clinical environments, and documentation.

Our team studied all aspects of the claims and, using benchmarked data, identified risk mitigation strategies that physicians and APPs can use to decrease the risks of injury, thereby improving the quality of care.

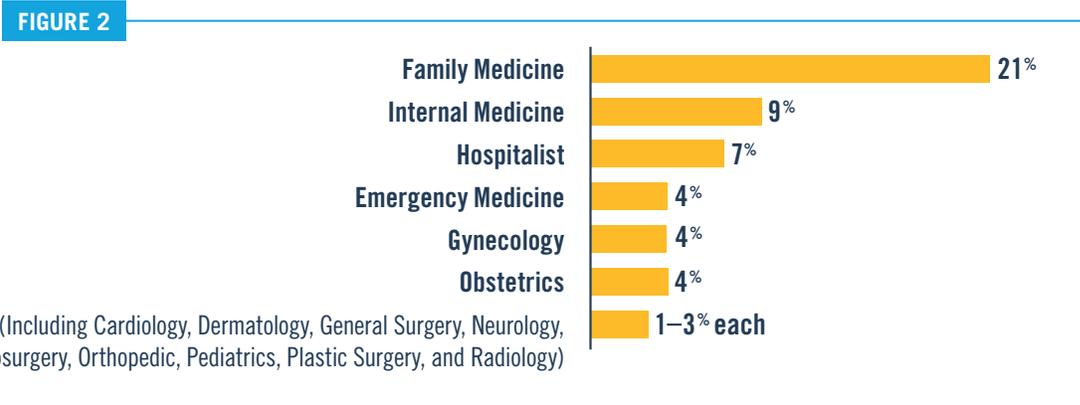
* A written demand for payment.

† Other advanced practice providers, such as CRNAs and CNMs, were not included in the study.

The distribution of medical malpractice claims, by provider type and medical specialty, is shown in **FIGURES 1** and **2**. The “responsible service” is the clinical service of the provider who was responsible for the patient’s care at the time of the event.



Source: The Doctors Company Closed Claims 2012–2017



Source: The Doctors Company Closed Claims 2012–2017

PHYSICIAN ASSISTANT AND NURSE PRACTITIONER CLOSED CLAIMS STUDY (continued)

As shown in **FIGURE 3**, the top allegation for both PAs and NPs was **diagnosis-related (failure, delay, wrong)**. Diagnosis-related (failure, delay, wrong) allegations were made when the patient's condition was incorrectly diagnosed or the diagnosis was delayed to the detriment of the patient's health.

FIGURE 3



	PA	NP
Diagnosis-Related (failure, delay, wrong)	37%	35%
Improper Management of Treatment	9%	16%
Improper Medication Management	9%	11%
Improper Performance of Treatment or Procedure	10%	8%
Improper Management of Surgical Patient	11%	3%
Improper Performance of Surgery	9%	2%
Wrong Medication	2%	2%

Source: The Doctors Company Closed Claims 2012–2017

Improper management of treatment was alleged when there were complaints about medical treatment. This allegation was related to a patient's belief that something was wrong with the selection or implementation of a treatment.

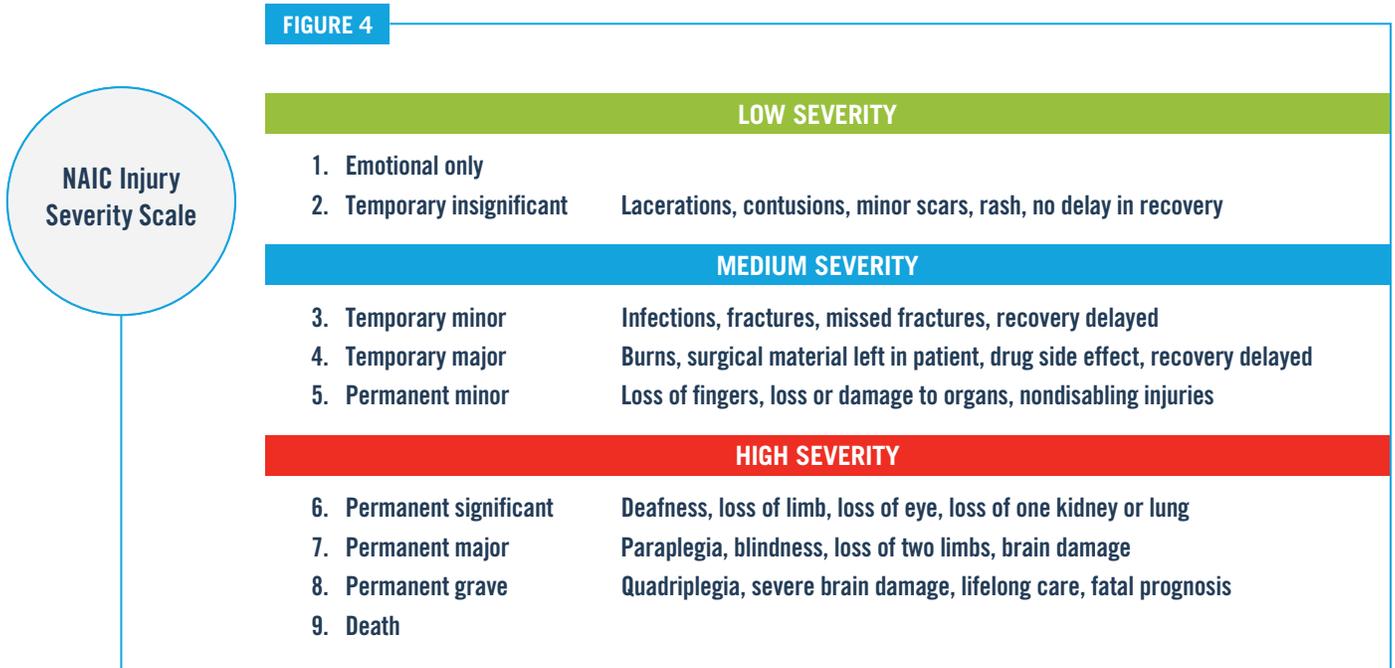
Allegations of **improper medication management** are related to failure to appropriately monitor high-risk medications (e.g., anticoagulants, narcotics, antibiotics), failure to address medication side effects, failure to identify drug interactions, or mismanagement of dosing. Allegations of **wrong medication** included ordering errors, such as ordering medications that were inappropriate for the patient's condition, prescribing medications that were contraindicated because of another medication the patient was taking, or ordering the wrong dose.

Both **improper performance of treatment or procedure** and **improper performance of surgery** allegations are associated with surgical specialties. These allegations are more common for PAs because they are more likely to work in surgical settings.

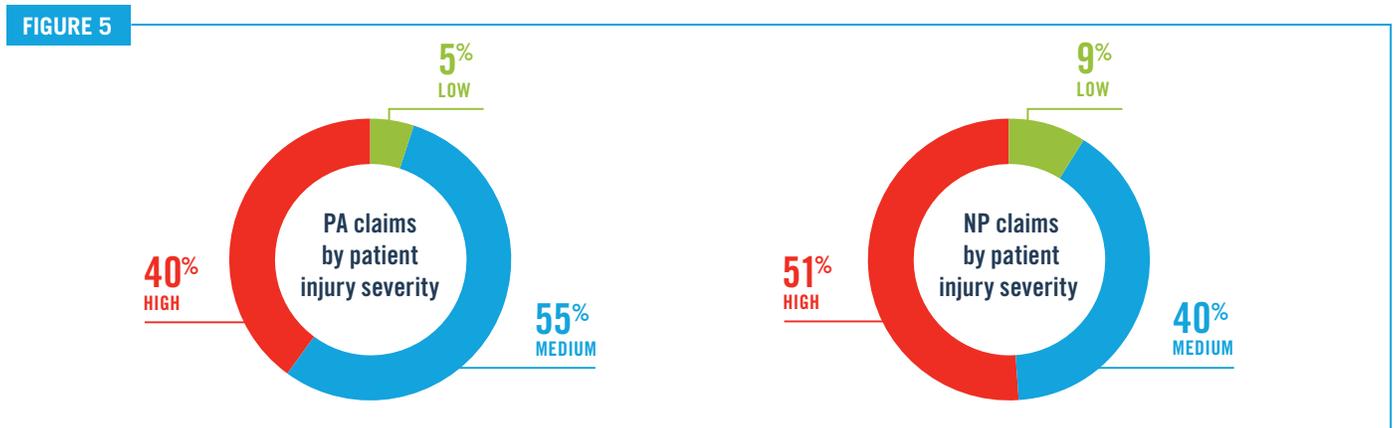
Improper management of the surgical patient focuses on the steps providers take in managing patients through the surgical procedure process. These events encompass all phases of the surgical process, including preoperative, intraoperative, and postoperative phases. Events occurred in the office, OR, postanesthesia care unit (PACU), or the patient's home.

Patient Injury Severity

Patient injury severity was identified using the National Association of Insurance Commissioners (NAIC) Injury Severity Scale (see **FIGURE 4**). The scale was rolled into low, medium, and high categories.



As illustrated in **FIGURE 5**, high-severity injuries and medium-severity injuries are reversed for the two types of APPs. Low-severity injuries are similar for each type. The large number of medium-severity injuries for PAs is related to their work in orthopedics, where the majority of claims fall within the medium-severity category.

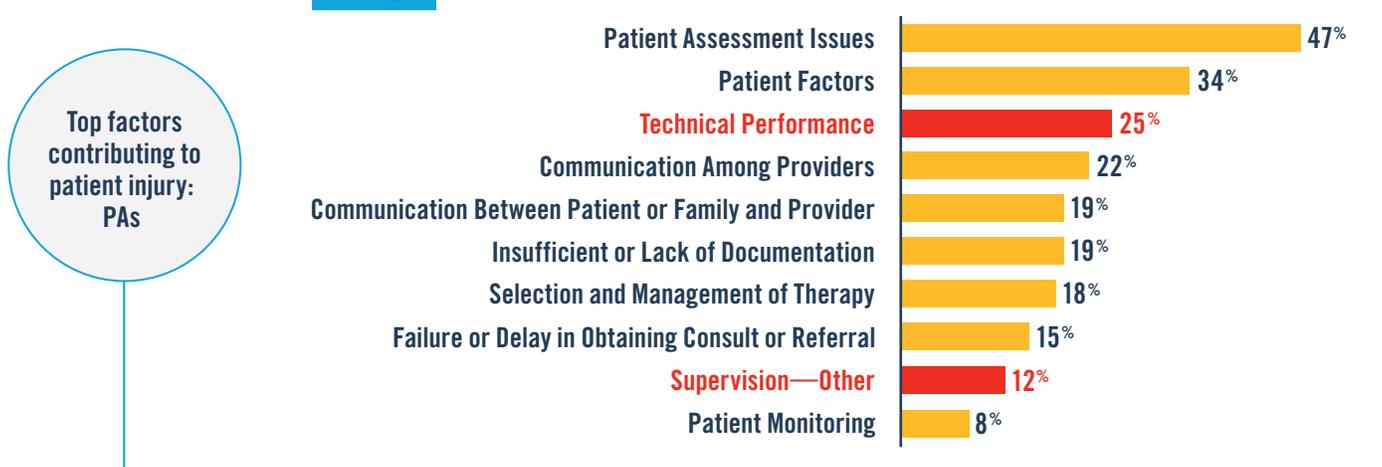


PHYSICIAN ASSISTANT AND NURSE PRACTITIONER CLOSED CLAIMS STUDY (continued)

Factors Contributing to Patient Injury

Practicing physicians evaluate our malpractice cases and identify factors that contributed to patient injury. **FIGURES 6 and 7** illustrate the top contributing factors identified by our physician reviewers. Note that because multiple factors often contributed to patient injury, the percentages total more than 100 percent.

FIGURE 6



Source: The Doctors Company Closed Claims 2012–2017

FIGURE 7



Source: The Doctors Company Closed Claims 2012–2017

The categories highlighted in red above differ between PAs and NPs by more than 10 percent.

Many contributing factors were similar in PA and NP claims:

Patient assessment issues: Nearly half of all PA and NP claims involved inadequate assessments. Inadequate assessments are closely related to a failure or delay in diagnosis. An incorrect diagnosis was often due to failure to establish a differential diagnosis or failure or delay in ordering diagnostic tests.



Patient assessment was the top factor contributing to patient injury.

Patient factors: Patient engagement is critical in healthcare outcomes. Patient factors were involved in 34 percent of PA claims and 25 percent of NP claims. Factors included noncompliance with the treatment plan or with a follow-up call or appointment.

Communication among providers: Communication among providers was identified in 22 percent of PA claims and 25 percent of NP claims. The APP did not communicate the patient's condition or failed to read the medical record.

Technical performance: Technical performance, found in 25 percent of PA claims and 12 percent of NP claims, is a contributing factor closely related to surgical cases. This factor often referred to complications known to the patient as a risk of the procedure and was not considered by the reviewer as substandard care. Incorrect surgical count was also associated with technical performance.

Selection and management of therapy: These factors, found in 18 percent of PA claims and 23 percent of NP claims, reflect a provider's decisions regarding the management of a patient's therapy. The therapies were not appropriate based on the patient's diagnosis. Examples included selection of medications and selection and management of treatment modalities.

Insufficient or lack of documentation: Physician reviewers identified insufficient or lack of documentation in 19 percent of PA claims and 18 percent of NP claims. Medical record entries by APPs in these cases were criticized for insufficient or lack of clinical findings and clinical rationale. Documentation was also deficient when it lacked entries by physician providers who were known to have provided care.

Observations

The data show the specialties in which both types of APPs work. A higher percentage of PAs work in surgical specialties, while more NPs work in primary care. The types of injuries that patients suffer while in the care of PAs and NPs reflect the specialties in which they work. NPs have more issues with diagnosis and management of medical treatment, while PAs face more issues related to diagnosis and surgical care.

APPs insured by The Doctors Company make up approximately 4.9 percent of our insured members and represent approximately 4.9 percent of claims filed. A review of the clinical descriptions for these cases indicates the primary risks for APPs are lack of supervision and failure to refer the patient to a physician when the patient returns with the same complaints.

CHECKLIST



- Develop written guidelines and protocols that specify an APP's responsibilities relative to examinations, assessments, diagnoses, treatment, prescriptive privileges, and administrative functions.
- Delineate in written guidelines and protocols how often the physician must see the patient and under what circumstances the physician must personally assess the patient.

PHYSICIAN ASSISTANT AND NURSE PRACTITIONER CLOSED CLAIMS STUDY (continued)

CASE EXAMPLE: PA



A 59-year-old female underwent redo quadruple coronary bypass grafting surgery times four, including a left internal mammary artery graft. Her medical history was significant for the original coronary artery bypass grafting 12 years earlier and well-controlled type II diabetes. Surgery was performed uneventfully by the cardiothoracic surgeon. It is noteworthy that the patient's white blood count (WBC) was 11.8 preoperatively; four days later, her WBC was 13.9 prior to discharge.

When the patient was next seen, the physician noted that she reported feeling well but complained of lightheadedness. The sternal wound was noted to be healing well, and the balance of the exam was unremarkable.

The patient's spouse subsequently testified that his wife complained of neck and shoulder pain during the visit. He called the physician's office two days later and spoke with a PA, who advised him to increase the patient's pain medication.

The patient's spouse also testified that he contacted the physician three days later and was again directed to the PA. He reported a continued complaint of pain. Although the medical record had no documentation of either phone call, the plaintiff produced evidence that the PA had, in fact, called in a prescription for pain medication.

The following day, the patient called and spoke with the PA, indicating that she was experiencing chest pain with movement and deep breathing. She was instructed to report to the ER for evaluation. The ER physician noted that the patient was taking hydrocodone for chest pain. An EKG was unremarkable. Her WBC was 14.8. The patient was prescribed Ultram and discharged with a diagnosis of "chest wall pain." The ER physician testified that he spoke with the physician's PA, but no documentation of that call was found in either the hospital record or the patient's chart.



The following day, the patient again phoned the physician and complained to another PA of neck and shoulder pain. The patient testified that the PA instructed her to continue taking the pain medication prescribed by the ER. Because of continuing severe neck pain and spasm, the patient sought care from a chiropractor, who noted a reddened, swollen area at the incision site and directed the patient to contact the physician.

That evening, the patient called the physician and was directed to a PA. She described her symptoms and was given instructions to continue the pain medications. Although the PA acknowledged the phone call, she had not documented it. The patient's spouse testified that he called the physician five times the following day, demanding that the patient be seen, before being given an appointment. Upon arrival, the patient was evaluated by a PA, who summoned a physician in the group to examine the incision. The physician admitted the patient, but she ultimately experienced diminished sensation below the diaphragm and underwent surgery for a ventral epidural abscess. Unfortunately, the patient was rendered an incomplete C6 quadriplegic.

A suit was filed against the physician, the physician's three PAs, and the physician's medical group practice, alleging that a delay in diagnosis of the sternal wound infection resulted in progression to an epidural abscess and subsequent quadriplegia.

CASE EXAMPLE: NP



A 41-year-old male presented to a primary care practice with complaints of fever and abdominal pain for four days with bright red blood clots from the rectum, anorexia, dehydration, nausea, and straining to defecate. The NP noted the abdomen was soft with diffuse tenderness and hypoactive bowel sounds but no masses. The anus and rectum were examined and were also negative for masses, fissures, or hemorrhoids. Family history was negative for colon cancer. The NP noted recent antibiotic therapy for methicillin-resistant *Staphylococcus aureus* (MRSA).

The NP ordered lab work, wrote prescriptions for Flagyl, Lomotil, and Percocet, and documented “possibly needs colonoscopy if tests yield nothing.” Laboratory results revealed an elevated WBC at 12,700 mcL (normal range 4,500–10,500 mcL) and erythrocyte sedimentation rate (ESR) at 43 mm/hr (normal range for males under age 50 is 0–15 mm/hr). His stool tested positive for *Clostridium difficile*.

Four days later, the patient returned with complaints of bloody diarrhea with abdominal pain. A urinalysis revealed a moderate amount of blood. The physical exam of the abdomen was positive for diffuse tenderness, but it was otherwise within normal limits for bowel sounds and no masses or distention. The NP recommended continuing Flagyl and a repeat urinalysis.

One week later, the patient presented with bright red blood from the rectum and a moderate amount of abdominal pain. The abdomen was soft and bowel sounds were within normal limits. The urinalysis was negative, but the NP recommended continued antibiotics.

One month later, the patient presented with complaints of abdominal pain, but the NP noted that the abdomen was soft, and no further treatments or testing was ordered.

Two months later, the patient was seen for bloody diarrhea over three days and abdominal pain. The NP ordered a stool culture and recommended that the patient avoid dairy products and take probiotics.

The patient continued to be seen over the next year with similar complaints.

One year later, the patient was referred for a colonoscopy due to complaints of diarrhea. The colonoscopy revealed a large sigmoid mass positive for stage IIIA cancer.

Defense experts were critical that the patient saw only the NP over a three-year period. No physician evaluated the patient, and the patient was not referred to a gastroenterologist.

FAILURE TO REFER THE PATIENT TO A PHYSICIAN

Patient presents to NP

Complains of rectal bleeding, fever, and abdominal pain.

Four days later

NP continues patient’s antibiotics and orders repeat urinalysis.

One week later

Patient’s symptoms continue. NP continues antibiotics.

One month later

Patient’s symptoms continue, but NP orders no further testing or treatment.

Two months later

Patient’s symptoms worsen. NP orders stool culture and recommends dietary changes.

One year later

NP refers patient for colonoscopy.

Over three-year period

Patient saw only the NP. No physician evaluation. No referral to gastroenterologist.

CERTIFIED REGISTERED NURSE ANESTHETIST CLOSED CLAIMS STUDY

A study of The Doctors Company claims involving CRNAs from 2012 through 2017 examined allegations and contributing factors. **FIGURES 8** and **9** provide the most common allegations against CRNAs and the top factors contributing to patient injuries.

FIGURE 8

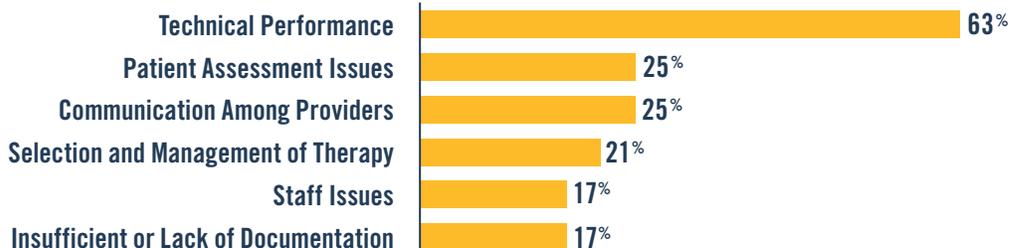
Most common patient allegations: CRNAs



Source: The Doctors Company Closed Claims 2012–2017

FIGURE 9

Top factors contributing to patient injury: CRNAs



Note: More than one factor may contribute to patient injury so the percentages total more than 100 percent.

Source: The Doctors Company Closed Claims 2012–2017

The “Overall Findings in APP Claims” chapter includes an analysis of overall findings.

We have included two case examples for APPs that specialize in anesthesiology: one for a CRNA and one for an anesthesiologist assistant.

CASE EXAMPLE: CRNA



A 72-year-old male with a history of rheumatoid arthritis presented for an arthroplasty of the right hip due to severe pain and dysfunction. The preoperative assessment by the CRNA documented the patient as a Mallampati class 2—easy intubation. However, upon induction of anesthesia, the CRNA was unable to visualize the vocal cords and was unsuccessful in intubating the patient after three attempts. Blood was noted in the mouth. The patient developed a laryngospasm, and the procedure was canceled.

The patient was admitted to the hospital for observation due to stridor and subcutaneous emphysema. A CT scan and swallow study revealed a perforation of the hypopharynx, requiring surgical repair and a five-week stay in ICU and the hospital with a feeding tube. The patient has ongoing difficulties with swallowing.

The CRNA failed to adequately assess the patient preoperatively to appreciate how the rheumatoid arthritis, stiff neck, and history of difficulty swallowing might affect successful intubation. The inability to view the vocal cords should have alerted the CRNA to the need for a flexible laryngoscope and that blind intubation attempts should have ceased. In addition, there was no evidence of informed consent for anesthesia listing perforation as a risk of intubation.

CASE EXAMPLE: AA



A 55-year-old obese male (BMI 36) was given general endotracheal anesthesia for an open reduction internal fixation of the right humeral shaft with bone grafting. The patient was placed in a lateral position with beanbags supporting his torso and hips. There was initial documentation of arm board restraints and that pressure points were checked and padded, an axillary roll was positioned under the left chest wall, and the right arm was on a padded arm board. At no time during the six-hour surgery did the AA document any further checks of the patient's position or padding.

At the end of the procedure, it was noted that a portion of the beanbags had moved, allowing the patient's hips to slump forward. In the PACU, the patient complained of severe pain in his left chest wall, and red-dened areas were noted in the left axilla, pectoral area, and thigh. The patient had no motor or sensory function in his left upper extremity and was ultimately diagnosed with a brachial plexopathy. He has continued complaints of burning pain and needs assistance with grooming and toileting. The AA and the anesthesiologist were held responsible for the patient's injuries.

FAQs



What are the physician's co-signing requirements for documentation by an APP?

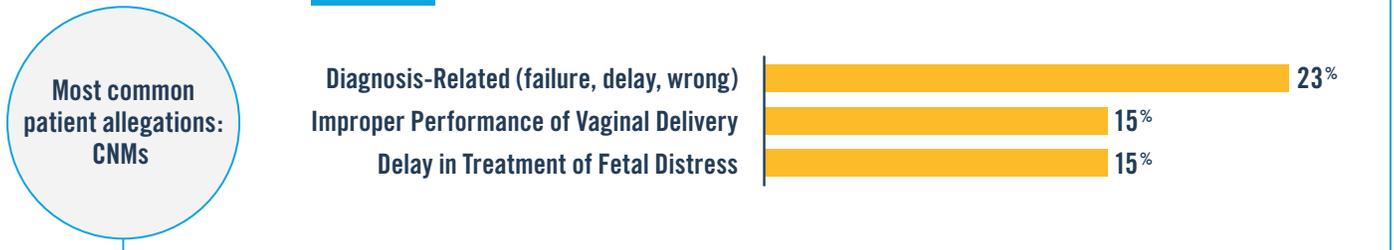
It varies. Each state has regulations that outline which APP type requires co-signature and which type of charts require review and co-signature. In addition, co-signatures may be required for some third-party reimbursement or as part of a standardized procedure. To reduce exposure to liability, a protocol for regular chart review for quality assurance purposes should be established.

At no time during the six-hour surgery did the AA document any further checks of the patient's position or padding.

CERTIFIED NURSE MIDWIFE CLOSED CLAIMS STUDY

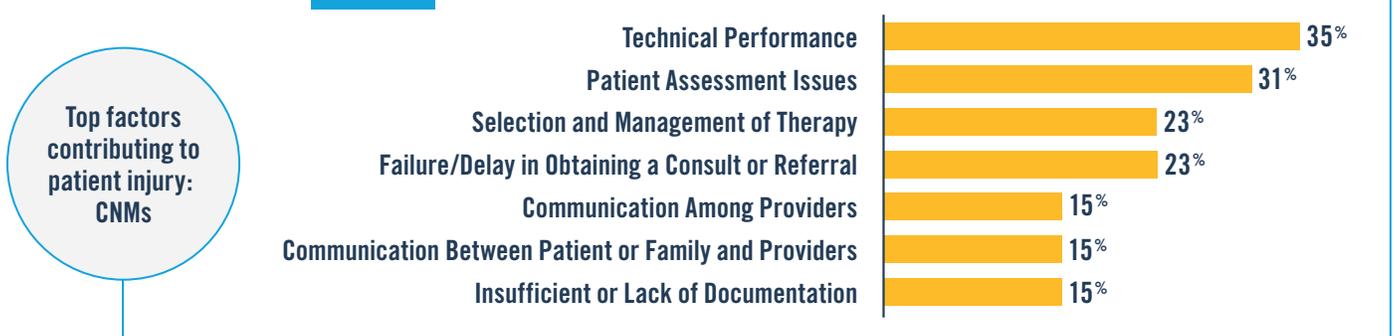
A study of The Doctors Company claims that closed from 2012 through 2017 involving CNMs examined allegations and contributing factors. **FIGURES 10** and **11** provide the most common allegations against CNMs and the top factors contributing to patient injuries.

FIGURE 10



Source: The Doctors Company Closed Claims 2012–2017

FIGURE 11



Note: More than one factor may contribute to patient injury so the percentages total more than 100 percent.

Source: The Doctors Company Closed Claims 2012–2017

The “Overall Findings in APP Claims” chapter includes an analysis of overall findings.

CASE EXAMPLE: CNM



A 32-year-old female, G4P3, with morbid obesity, gestational diabetes, and Group B Strep was induced at 39 weeks for a large gestational age baby. Artificial rupture of membranes yielded clear fluid; Pitocin and Cervidil were administered. The patient’s cervix was completely dilated and effaced; she was pushing and began to crown. Upon delivery of the fetal head, the top part of the face delivered and the CNM encountered a shoulder dystocia. The patient was repositioned with McRoberts maneuver, and then Woods screw maneuver and suprapubic pressure were used. The infant delivered in a left occiput anterior (LOA) position with a compound presentation (right hand at the chin). The patient suffered a periurethral laceration (which was repaired). The infant weighed 8 pounds, 15 ounces, with Apgar scores of 7, 8, and 9.

The infant’s right arm was not moving after delivery and remained flaccid upon discharge. The infant has severe mobility dysfunction involving all five nerves of the brachial plexus. Surgeries have resulted in minimal improvement.

Experts were critical of the CNM’s management of the patient, including delivering a high-risk patient, not knowing the position of the infant, not consulting with the OB physician during labor and delivery, and inadequately documenting the medical record in some places.

OVERALL FINDINGS IN APP CLAIMS

Failure to Diagnose and Delay in Diagnosis

Primary factors associated with the allegation failure to diagnose and delay in diagnosis are lack of physician supervision and failure of the APP to consult with the physician. Findings included APPs who misinterpreted information provided by patients and APPs with inadequate levels of experience in diagnosing and managing particular conditions.

When APPs are uncertain about a diagnosis or a plan of care, they are required to consult with their supervising physicians. Liability exposure in these situations is reduced when the APP follows the established protocols prescribed by statute.

The importance of documenting the patient's clinical symptoms with specificity cannot be overstated. Successfully defending failure to diagnose and delay in diagnosis claims often depends on supporting the APP's clinical rationale in the face of otherwise silent clinical symptomatology.

Failure or Delay in Obtaining Specialty Consultation or Referral

An allegation associated with failure or delay in obtaining a specialty consultation or referral involves APPs who independently manage a complication that is beyond their expertise, skill set, or scope of practice. Patient safety and risk management findings include overconfidence in skill set, lack of communication between the APP and supervising physician, and patient compliance issues.

Physicians and APPs have legal and ethical obligations to refer patients to specialists or order specific diagnostic tests when indicated based on a patient's presenting signs and symptoms. To further reduce exposure to liability, all uncertain diagnoses or courses of diagnostic treatment to determine a diagnosis must be communicated to the supervising physician and a specialty referral should be made when indicated. Documentation is critical to successfully defending a claim. The chronology should include initial workup, internal consultation if indicated, specialty referral submission if indicated, and a documented plan of care based on referral findings.

Inadequate Evaluation and Physical Exam

Failure to perform an adequate patient assessment or exam occurs when the APP relies on a previous medical record history and other sources to determine the diagnosis, rather than performing a comprehensive exam.

CHECKLIST



- Instruct all APPs to consult with a physician whenever they are in doubt about the treatment of a patient.
- Establish criteria for periodic review and evaluation of APP medical record documentation.

Documentation is critical to successfully defending a claim.

Communication Issues

Patient-provider communication issues are associated with failure to interview the patient. This situation leads to inadequate knowledge of current medications, illnesses, and any changes that may be contributing to a patient's signs and symptoms. It may also lead to an inappropriate plan of care. To reduce liability exposure in this area, the APP must perform a thorough physical exam, including a review of the medical history and current complaints communicated by the patient. Documenting complete findings will reduce exposure to liability while ensuring continuity of care.

The following case example illustrates factors discussed above.



CASE EXAMPLE: CNS



A 42-year-old male presented to the CNS in a primary care practice for a mole check on his forearm. The mole was thought to be benign and was not biopsied. The primary care physician was not consulted, and the patient was not referred to a dermatologist. The patient was seen by the CNS on two other occasions over the next eight months for unrelated conditions. One year later, the patient moved to another area and was seen by a dermatologist who removed the mole. The biopsy came back positive for melanoma that had spread to the lymph nodes.

The CNS and the primary care physician were found to be responsible for the failure to follow up with the patient about the mole, failure to obtain a dermatology consultation or referral, and for the subsequent delay in diagnosis.

EXPOSURE TO DISCIPLINARY ACTION



If a physician fails to supervise an APP or allows an APP to practice outside the scope of his or her license, the physician can be subjected to a review or investigation by the state medical board and face subsequent action that can affect his or her medical license. The state medical board can charge the physician with unprofessional conduct or with aiding in the unauthorized practice of medicine. Physicians should be aware that a medical malpractice action can also trigger a medical board review and that

a review can be initiated separately. Adverse actions may include restriction, suspension, or revocation of the license to practice.

Each state board of medicine and state nursing board has jurisdiction for managing the disciplinary actions of licensed APPs. APPs may also be subject to licensing board actions for violations such as failing to practice according to the standard of care or practicing outside the scope of their license.

All states require a supervising physician for PAs. When a lack of supervision is discovered, the physician and PA are often both subject to discipline. For APRNs, many states require the use of standardized procedures. Similar to PAs, if the APRN does not follow procedures, disciplinary action can be taken by both the state's board of nursing and its medical board.

Criminal acts and quality-of-care concerns are examples of issues that can lead to investigations by state licensing boards. In many states, a licensed individual who is found guilty of a crime committed outside of work, such as driving while intoxicated, can be subjected to disciplinary action by a licensing board. Quality-of-care issues or drug diversion may warrant notification by an employer to a licensing board. These situations may result in suspension of the physician's or APP's license, followed by revocation if there is no subsequent evidence of competency to perform duties or completion of a specified drug diversion program.

Each state board and many professional associations have code of ethics language that all licensees must follow. State boards may investigate any concerns.

Check your state board and professional designation websites to learn more about disciplinary actions, codes of ethics, and professional scope of practice.

CHECKLIST



- Obtain and review state licensing board requirements periodically.
- Remain current on and comply with APP licensure requirements, scope of practice, and supervisory limitations.

Quality-of-care issues or drug diversion may warrant notification by an employer to a licensing board.

LIABILITY CONCERNS

Many malpractice claims attributed to APPs can be traced to clinical and administrative factors:

- ▶ Failure to adhere to the scope of practice.
- ▶ Inadequate physician supervision or oversight.
- ▶ Absence of written protocols.
- ▶ Deviation from written protocols.
- ▶ Failure or delay in seeking a referral or physician collaboration.

Consequently, physicians who use APPs should take precautions to ensure that the APPs are not providing services beyond their capabilities or those permitted by law.

Monitor the APP's work closely until a comfort level with his or her abilities is achieved, then continue monitoring the APP at regular intervals to ensure ongoing quality performance. State laws and regulations may establish requirements for monitoring an APP's ongoing performance and for documenting that the necessary oversight took place.

Monitoring the APP's performance enables the physician to detect misdiagnoses, delays in diagnoses, improper orders, or any other issues requiring attention.

CHECKLIST



- Test competency and document performance evaluations periodically.
- Ensure all staff members and other physicians in the practice understand an APP's role and limitations.



EMPLOYMENT AND CONTRACTING CONCERNS



Using an APP may lighten a physician's caseload, improve patient satisfaction, and lower the expenses of running a practice. To avoid increasing liability exposure, however, physicians must work with qualified individuals. The same considerations apply to any employees or independent contractors associated with the practice.

The hiring process requires thoroughly screening and verifying the credentials of all prospective employees or independent contractors to ensure they are qualified and well trained. Independently verify all licensures and credentials, contact references, and conduct additional background inquiries.

Proactively managing employment-related issues can protect patients from harm caused by unqualified staff and decrease liability exposure for the practice. A detailed background review, original source verification, and ongoing competency training and evaluation can also help to prevent hiring or contracting with individuals who have fraudulent credentials.

CHECKLIST



- Use a skills checklist to assess a candidate's clinical skills prior to employment.
- Verify that all staff members' licensing and certification requirements are current.

The following strategies can assist when hiring or contracting with APPs:

- ▶ Verify the applicant's credentials and prior experience as thoroughly as you would that of a physician. Verify qualifications with original sources.
- ▶ Obtain authorization to conduct credit, reference, and police background checks.
- ▶ Use a skills checklist and consider proctoring for a period of time to determine any required additional training.
- ▶ Obtain hospital privileges for each APP, if needed, but don't rely solely on the hospital's credentialing process.
- ▶ Develop written guidelines for examinations, treatment, delegation, supervision, chart reviews, and consultations with the supervising physician.
- ▶ Educate other members of your staff and on-call physicians about the APP's role and limits.
- ▶ Be thoroughly familiar with the state statutory requirements, limitations, and licensing guidelines that affect the type of APP to be hired or contracted with, especially regarding your responsibility for supervision or oversight.
- ▶ Insist that all employees and independent contractors, including your APPs, wear badges so that patients can distinguish each staff member's name and role.
- ▶ Use surveys to determine your patients' satisfaction with the care and services they receive, including care provided by APPs.
- ▶ Obtain professional liability insurance coverage for all employed APPs, and verify coverage for independent contractors by obtaining a valid certificate of insurance each year.
- ▶ Notify your professional liability carrier of any changes to the scope of practice or employment status of your APPs.

POLICY AND PROCEDURE MANUALS

Policy and procedure manuals can be valuable reference tools for physicians and APPs. Manuals can be written for both the clinical and administrative aspects of your practice. Properly written, they encourage consistency and adherence to clinical practice guidelines. In contrast, poorly drafted and outdated policy and procedure manuals can increase liability exposure for your practice. Failing to adhere to written policies and guidelines can also increase liability exposure and undermine the defense of a malpractice claim.



The following guidelines can assist physicians and APPs when developing policy and procedure manuals:

- ▶ Address clinical procedures with specificity.
- ▶ Make policies and procedures succinct and easily understood by all staff.
- ▶ Review and update manuals as needed.
- ▶ Avoid protocols that may create unrealistic standards for the practice.
- ▶ Date revisions to policies and procedures as they are made.
- ▶ Collect and archive all old policies to prevent inadvertently using an outdated policy.
- ▶ Retain all archived material indefinitely, if possible, or according to state regulatory or accreditation requirements.
- ▶ Provide education on new policies and procedures and require staff members to read and acknowledge their understanding.
- ▶ Educate new staff and review current policies and procedures with all staff.
- ▶ Update protocols adopted from reference materials.

Position Descriptions

Creating position descriptions can help ensure that employees and APPs practice within their scope and follow appropriate guidelines. Descriptions can also help in meeting state statutory requirements. A written description memorializes the APP's scope of practice, specifies the roles and responsibilities of the APP and supervising physician, and clarifies supervision guidelines. Written standardized policies and procedures may be required for APPs with prescriptive privileges. Some states provide sample agreements for physicians to use.

When drafting position descriptions:

- ▶ Specify the maximum number of APPs a physician may supervise, based on state regulations.

EXAMPLE: The APPs are supervised by licensed physicians. All care is rendered in accordance with the guidelines set forth by the State Medical

Board (and State Nursing Board, if applicable) and applicable law. *[Specify the number of APPs the physician can supervise.]*

- ▶ Define the duties and responsibilities of each APP clearly, including minimum knowledge, clinical skills, and abilities required for the job.

EXAMPLE: The APP may treat and manage acute and chronic medical problems of patients in a primary care setting, including interviewing patients, obtaining and recording health histories, performing physical assessments, ordering appropriate diagnostic tests, diagnosing health problems, managing the healthcare of patients for which he or she has been educated, providing health teaching and counseling, initiating referrals, and maintaining health records. Medications are prescribed as outlined in the protocols, and physician supervision is provided in accordance with the applicable law for APPs.

- ▶ Identify consultation guidelines that specify when APPs must seek guidance from the supervising physician.

EXAMPLE: The physician will be consulted for the following conditions: *[List medical conditions or clinical situations].*

- ▶ Identify the license or certification required by statute or regulation.

EXAMPLE: Certification of approval from the State Board of Medicine, and, if a nurse practitioner, licensure from the State Board of Nursing.

- ▶ Identify mandatory certifications and continuing education (CE) requirements.

EXAMPLE: Fulfills mandatory educational requirements annually *[list requirements]*, which include, but are not limited to, The Joint Commission and other institutionally required education; BLS and ACLS, or appropriate certification related to specialty; and CE hours, as required by specific APP national certification.

- ▶ List the drug therapies that the APP may prescribe, initiate, monitor, alter, or order.

EXAMPLE: The APP may prescribe, initiate, monitor, alter, or order the following medications: *[List medications or classifications according to the APP's prescriptive authority as outlined by state law and granted by the licensing body].*

- ▶ Specify the physician's duties for supervising or overseeing APPs.

EXAMPLE: The physician will provide general supervision for routine healthcare and management of common health problems and provide consultation and/or accept referrals for complex health problems. The physician will be available by telephone or by other means of communication when not physically available on the premises. If the physician is not available, his or her associate, *[Name of Physician, MD/DO, License #XXXXXX] [or other description of designated doctor(s) or groups]*, will serve as backup for consultation, collaboration, and/or referral purposes.

- ▶ Include the signature of the APP and supervising provider.

EXAMPLE: All parties to this agreement share equally in the responsibility for reviewing treatment protocols at least annually or more frequently as needed.

CHECKLIST



- Keep clinical guidelines up to date.
- Develop written job descriptions.
- Have employees acknowledge employment policies and procedures and confidentiality statements.

PATIENT SAFETY AND RISK MANAGEMENT CHECKLIST

Pre-Employment

- Use a skills checklist to assess a candidate's clinical skills prior to employment.
- Obtain authorization to conduct credentialing and background verification for a candidate.
- Check a candidate's credentials and licensure status carefully before employment.



Licensing, Certification, and Privileging

- Verify that all staff members' licensing and certification requirements are current.
- Obtain APP hospital privileges, when required.

Training and Environment

- Ensure that newly hired APPs undergo orientation to the practice.
- Require staff and APPs to wear name badges delineating their titles.
- Foster open communication among all staff members in your office.
- Ensure that all staff members project a professional demeanor.
- Encourage and promote continuing education among APPs and all staff.
- Ensure the staff schedule includes time off, vacations, and equitable workload.
- Promote an environment in which staff can report errors without fear of reprisal.
- Implement a staff attitude assessment to identify culture issues that may affect patient safety.
- Provide patient safety and risk management training to all staff.

Job Descriptions, Employee Handbook, Guidelines, and Protocols

- Develop written job descriptions.
- Develop written guidelines and protocols that specify each APP's responsibilities relative to examinations, assessments, diagnoses, treatment, prescriptive privileges, and administrative functions.
- Delineate in written guidelines and protocols how often the physician must see the patient and under what circumstances the physician must personally assess the patient.
- Clarify the type and extent of physician supervision or oversight required by state laws.
- Ensure that all tasks assigned to an APP are within both the physician's and the APP's competence and scope of practice.

- Ensure that all staff members and other physicians in the practice understand an APP's role and limitations.
- Develop an employee handbook.
- Have employees acknowledge employment policies and procedures and confidentiality statements.
- Instruct all APPs to consult with a physician whenever they are in doubt about the treatment of a patient.
- Keep clinical guidelines up to date.

Performance Evaluations and Competency

- Test competency and document performance evaluations periodically.
- Establish criteria for periodic review and evaluation of APP medical record documentation.
- Monitor an APP's prescription practices and maintain a current copy of his or her DEA certificate.
- Conduct annual performance evaluations for all APPs and staff.
- Include patient safety and patient satisfaction in evaluation criteria.

State and Licensure Requirements

- Obtain and review state licensing board requirements periodically.
- Remain current on and comply with APP licensure requirements, scope of practice, and supervisory limitations.

Patient Interactions

- Consider providing disclosure language in patient authorizations and/or consent forms indicating that treatment will be rendered by APPs under your supervision.
- Determine patient satisfaction with the APP care provided.
- Determine patient satisfaction with the practice overall.
- Reassure patients that they will be seen by a physician when the patient, the APP, or the physician feels it is necessary.
- Document all communications between the physician and APP.

Business Operations

- Maintain copies of professional liability insurance coverage.
- Notify managed care plans when required of APP participation in patient care.
- Notify insurance carriers promptly of APP staffing changes.

FREQUENTLY ASKED QUESTIONS



Is a PA required to have written protocols in order to practice?

It depends. While it is strongly recommended that a PA practice under written protocols in all clinical settings, many states require written protocols only in certain practice settings. However, all states require a supervising physician for a PA to practice in any setting.

How many APPs is a physician allowed to supervise?

The ratio of APPs to supervising physician varies. While the American Medical Association does not state a specific ratio, it recommends that the appropriate ratio of physician to APPs should be determined by physicians at the practice level, consistent with good medical practice and state law where relevant. In some states, the ratio is specified and may be based on whether the APPs are furnishing or prescribing medications. It is also important to maintain a ratio consistent with any terms specified in your professional liability policy language.

Is the scope of a PA's practice determined by the supervising physician?

Yes. State law permits a PA to practice within the scope of practice of the supervising physician. It follows that a PA's scope of practice may be defined by the limitations set forth by the supervising physician in coordination with the PA's education, training, and experience.

What are the physician's co-signing requirements for documentation by an APP?

It varies. Each state has regulations that outline which APP type requires co-signature and which type of charts require review and co-signature. In addition, co-signatures may be required for some third-party reimbursement or as part of a standardized procedure. To reduce exposure to liability, a protocol for regular chart review for quality assurance purposes should be established.

Does the name of a licensed physician need to be on prescriptions issued by an APP?

It depends on state law, the type of APP, and the prescribing privileges. If required, consider that in the case of on-call coverage, the alternate physician's name may need to be indicated.

Which drugs can a prescribing APP write prescriptions for?

While states may allow many types of medication prescriptions within formulary standards (including controlled substances with a DEA registration number), some states impose restrictions on prescribing authority.

Some states have adopted requirements for APPs to complete advanced courses in pharmacology before they are allowed prescribing privileges, especially for controlled substance prescribing. An NP's standardized procedure must outline what is allowed, while a PA's supervising physician decides what is allowed through delegation (in coordination with state laws for prescribing certain pharmaceuticals). Although a written protocol may not be required in certain states and practice sites, it is highly recommended that written protocols with a specified formulary for prescribing should accompany the delegation of services.

Does a change in employment affect an APP's prescribing privileges?

The answer depends on state law and regulation. Prescribing privileges, while allowed through licensure, may require approval by the employer, physician, or practice location and may also require submission of new information to the respective licensing board, depending on the state of practice.

Can an APP with prescribing privileges sign for medications received from a pharmaceutical representative?

Yes, but generally only for medications that the APP is authorized to prescribe. Check state laws on prescribing authority.

Does a supervising physician have to countersign prescriptions written by a PA?

No, provided the prescription is for an approved drug on the formulary that is on file with the supervising physician.

Can an APP dispense medications?

The answer depends on state law and regulation. In some cases, an APP may dispense sample medications as indicated by prescribing privileges.

What are the legal differences between an NP and a PA?

An NP's scope of practice varies from state to state. In many states, NPs are permitted to practice independently without the supervision of a licensed physician, depending on the practice setting. However, NPs often practice under the guidance of a licensed physician. A PA is licensed to practice medicine only under a supervising physician. While practicing under a physician's license, a PA can conduct physical exams, diagnose and treat illnesses, order and interpret tests, and (in many states) write prescriptions.

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